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ABSTRACT

Discussion explores the role of guilt in depression, arguing that "how children come to view themselves as pervasively responsible for bad things that happen" is a key element in the social transmission of affect that involves guilt. "Guilt" basically is an adaptive emotion that involves thoughts of remorse or responsibility for wrongdoing. While adaptive, it is susceptible to dysregulation. In fact, research indicates that some forms of depression may be transmitted socially from parent to child. One mechanism mediating the transmission plausibly might be the early learning of excessive guilt. Until recently, this was not a tenable surmise, because very young children were not believed to have well-internalized feelings of responsibility. Recent research, however, indicates that guilt develops in the second year of life, a time when children increase in their capacity to share with, sympathize with, help, and comfort victims in distress. Since young children exhibit difficulty in distinguishing between problems they cause and those they observe, it is possible that early forms of empathy and guilt may easily become confused. Such young children may be particularly vulnerable to feelings of responsibility for problems not of their own making, and to developing unrealistic guilt, especially if their causal role in distress events is over-emphasized by caregivers. Additional findings are discussed. (RH)

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Patterns of Guilt in Children of Well and Depressed Mothers[1]

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PS

I will be talking about the role of guilt in depression. I will be suggesting that there may be an important causal link between excessive guilt in early childhood and the later emergence of depression. Guilt refers to thoughts and feelings of remorse or responsibility for wrongdoing. From an evolutionary perspective, it is an adaptive emotion. It prevents exploitation and destruction, and restores social harmony through acts of reparation. Guilt may become dysregulated however. When there is too much or too little guilt, when it becomes defended against or projected onto others, or when it is for imagined rather than real transgressions, it causes problems for individuals and relationships. And it becomes a key element of some emotional disorders.

Depression is characterized by prolonged periods of sadness and apathy. Some symptoms are physical and include disturbances in activity, sleep, and eating patterns. Other symptoms reflect psychological processes that include feelings of guilt, worthlessness and low self-esteem. In Seligman's reformulated attribution theory, depression, in fact, is defined by self-attributions of responsibility for negative events that are consistently internal, stable and global. In other words, the depressed person feels responsible for everything that goes wrong and guilt is exaggerated.

Depression is more prevalent in some families, and intergenerational patterns have been identified. There is likely a genetic basis for some forms of the disorder. Environmental factors, particularly negative life events relating to loss also have been implicated as causes. Loss may be psychological as well as physical (i.e., the emotionally unavailable caregiver) One way to explore the development of depression is to examine the origins of symptoms that

define the disorder. Guilt may contribute to, as well as index, some forms of depression. Hence, information about the early development of pervasive feelings of responsibility might help to understand the later emergence of emotional disorders in which guilt plays a role.

Exposure to depression in a caregiver has been shown to create negative affect in infants and young children. (This is the work of Tronick, Cohn and others.) Initially children often try hard to engage an unresponsive mother and attempt to "repair" the interaction. When they fail, they become emotionally distressed and withdraw. Through a process of conditioning or contagion, the mother's negative affect becomes mirrored in the child. Most theories of social transmission have focused on how <u>emotions</u> of sadness and distress become perpetuated. We believe there is another key element in the transmission process that involves guilt -- and how children come to view themselves as pervasively responsible for bad things that happen. Parental depression provides a useful model for exploring this issue. It creates a situation of global suffering in which the child may begin to take responsibility for the parent's problems.

This process is illustrated in the next set of slides. (SLIDES) They are from a children's book, but the themes represent concepts found in formal theories of guilt and illustrate a pattern identified in our research (to be described). A mother is sad and her young daughter tries to help. First, the girl tries to read the mother a book. She jumps for the mother to make her happy, but the mother says it makes her dizzy. She sings a song but the mother says it makes her feel sad. She draws a picture, brings the mother cookies, and then a bear. The girl brushes her mother's hair, but the mother says it pulls and hurts, and starts crying. Finally, the girl says she will leave the mother because maybe that will make her happy. The mother responds by asking the child

not to leave because that would make her very sad.

It is reasonable to infer that the child here has learned through her close involvement, to feel responsible for the problems of an adult. Despite her extensive repertoire for giving, she is criticized and blamed for her efforts and is ineffective most of the time. And she becomes an enmeshed participant in the depression. Distinctions between empathy and guilt become blurred here. Both emotions reflect feelings of involvement and responsibility for the problems of another person. They differ mainly in whether or not the self has caused the other's distress. When the cause becomes unclear, empathy may effectively becomes guilt. When caregivers are overwhelmed, they may seek others, including their children, with whom to share the burdens and blame. Specific socialization practices and discipline methods, as well as a general climate of negative emotions, may encourage excessive guilt. A number of studies are relevant here.

Depressed mothers model negative attributional styles (i.e., explicitly conveying that they are at fault). They make more negative attributions about their children (Radke-Yarrow). They report more guilt- and anxiety-induction procedures in discipline situations. Finally, they may more often use love-withdrawal. In addition to the withholding of affection, love withdrawal conveys high maturity demands and disappointment when expectations are not met. Cumulatively, these studies suggest that some forms of depression could be socially transmitted from parent to child, and across generations. One mediating mechanism might be the early learning of excessive guilt. Until recently, this was not a tenable position because very young children were not believed to have well-internalized feelings of responsibility.

Psychoanalytic and social-cognitive theories, for quite different reasons, both targeted the early- and mid-elementary school years as the time of life when

internalized guilt emerges. Since very young children have neither a well-developed superego nor a fully integrated ego or self system, neither guilt nor depression would be expected early in development. Indeed, many investigators have found that guilt increases with age during the early- to mid-elementary school years. And childhood depression is, in fact, relatively rare. Moreover, guilt and negative self-esteem only begin to characterize the depression of older children and adolescents.

However, other developmental perspectives suggest the presence of guilt quite early in life. Kagan, Hoffman, Radke-Yarrow, myself and others have suggested that children as young as two have already acquired an appreciation of moral standards. In this view, guilt is not simply fear-based or reflexive to the commands of parents. In Hoffman's model, (adaptive) guilt derives from empathic concern that, in turn, develops out of an innate capacity for emotional arousal and sensitivity to others' distress.

Our research indicates that guilt develops in the second year of life. There are marked individual differences by then, in children's remorseful and reparative reactions to real and perceived wrongdoings, suggestive of different developmental pathways. We have examined guilt following children's misbehaviors. But we have also emphasized children's attempts to deal with problems that are not of their own making but for which they may still feel responsible. This is where irrational guilt may be learned.

Altogether several hundred preschool and school-age children have been studied at NIMH. Research methods included naturalistic observation, experimental manipulations, semi-projective procedures and psychiatric interviews. Some of the studies were longitudinal in design with children observed over the entire second year of life. (Slide of collaborators).

In our first studies of normative developmental processes mothers were trained to observe their 1- and 2-year-old children's responses to distresses and problems of others. Mothers reported situations in which the child observed someone else's problems (e.g., child sees father crying) and in which the child causes a problem (e.g., child bites and hurts sibling). Mothers also simulated emotions each week in the home. And on several occasions, distresses were simulated by others and videotaped in a laboratory setting.

The next slides (SLIDES) show developmental progressions in children's sympathetic and reparative behaviors in the original study and in a replication sample. There are significant increases with age, especially between 1 1/2 and 2 years in children's behaviors. Children help, share, sympathize and comfort victims in distress. The same pattern is present both when children cause others' distress (SLIDE) and when they witness it. (SLIDE) And the pattern is replicated under more controlled conditions both when distresses are simulated in the home (SLIDE) and in the laboratory (SLIDE). In another study of 2-year-olds we found that a majority of children engage in reparative behaviors during experimentally arranged mishaps (so the findings are robust). This early capacity to assume responsibility for self and other, to care for others and to care about the consequences of one's actions is a landmark achievement in development.

When children help someone they have harmed, this is usually defined as reparation for wrongdoing, and conceptualized as conscience or guilt. When children observe others' distress, the same prosocial behaviors are interpreted as altruism or empathy. Since it is hard for young children to distinguish between problems they cause and observe, early forms of empathy and guilt could easily become confused (they are correlated). Thus, this may be a time in

development where children are particularly vulnerable to feelings of responsibility for problems not of their own making, and hence to develop unrealistic guilt, especially if their causal role in distress is over-emphasized by caregivers. Some mothers did focus on children's blameworthiness. They were judgmental, conveyed exceptionally high standards, and used love withdrawal. They also emphasized how much the child's behavior hurt them. Such parental practices may foster maladaptive guilt and overinvolvement in others' distress.

We then explored further, family conditions that encourage these patterns in children. A theme in the literature on divorce and marital discord concerns the precocious and unrealistic level of responsibility that children assume for parents' problems. We have found that even very young children become involved in arguments between parents. (SLIDE) We compared two-year-olds from high conflict and low conflict homes. Children from high conflict homes became more emotionally aroused. And they intervened more than children from low conflict homes -- trying to get the parents to stop, to comfort one of them, or to get them to make up. We have observed a similar pattern of emotional arousal in a laboratory study in which two-year-olds observed two unfamiliar adults engaged in an argument. In this study, children of depressed mothers were particularly likely to become upset. In another study of 2- and 3-year-olds, (part of a larger study by Radke-Yarrow) depressed and well mothers were asked to act sad. Children of depressed mothers made more frequent and more different types of comforting reactions than children of well mothers, possibly reflecting empathic overinvolvement. (SLIDE) Their behaviors were often like those of the child described earlier, where empathy and guilt became in distinguishable. (SLIDE).

In a recent study of 5- to 9-year-olds differences in children of depressed and well mothers were again identified, but the picture becomes more complicated.

Assessments of guilt in a psychiatric interview showed similar increases with age for both groups of children. (SLIDE) However, the underlying dynamics may differ. We asked children in another procedure to interpret stories accompanied by photographs, e.g., two children fight over a bike and then make up; a mother is described as angry and leaving the house, and the child watches her leave; a sibling stands over the baby's crib; a mother cries on the phone. Consistent with many other studies, explicit, direct, functional expressions of guilt and empathy (involvement) increased with age. But this was true only for children of well mothers. (SLIDE)

Children of depressed mothers actually showed more of this involvement at the younger ages, but then it stopped. These same children however, showed distortions in their story narratives. Guilt themes were exaggerated, unrealistic, bizarre, fearful, violent, lacking in simple, direct resolutions to problems. (SLIDE) Within a psychodynamic framework, such expressions of painful experiences that follow real or perceived transgressions have been viewed either as expressions of guilt or unconscious, defensive manifestations of guilt. The forms and functions of guilt thus appear to differ for children with an emotionally ill caregiver. Unresolved guilt, which may begin early as overinvolvement with the parents emotional problems, shows further distortions later in development and ultimately may be a basis for some emotional problems.

Within the broader context of attachment, Bowlby has discussed ways in which temperament and environment interact to create different developmental pathways and intergenerational transmission patterns. One hypothetical maladaptive developmental pathway deviates toward anxious attachment and depression. (SLIDE) Its precipitating factors include guilt-inducing discipline and maternal loss. He contrasts this with a developmental pathway that deviates toward antisocial

conditions. (SLIDE) Main and Goldwin have studied the perpetuation of one type of anti-social pattern. They are able to predict mother's hostility and rejection of her infant from the caregiver's representation of her own experiences with rejection and abuse. They also have found that many young abused children show abusive and rejecting behaviors toward others.

Our own research is more pertinent to the first pathway, focusing on transmission of internalizing problems. It identifies similar patterns of unhealthy acceptance of responsibility in both mothers and their children. Children exposed to chronic distress in others are likely to feel the suffering intensely and may feel victimized or "burdened," because their own needs are not being met. Conditions of burden often create feelings of self-sacrifice and martyrdom in adults. These conditions are often closely linked both with feelings of guilt and the need to include others in the suffering. Children may develop such feelings as well and hence be inclined both to experience and induce guilt as they grow older. This could make them more vulnerable to depression and perpetuate the process across generations.

Guilt may be acquired and transmitted in other ways, and depression has other causes. Moreover, the outcomes we have described are not inevitable. There may be positive outcomes as well, or special sensitivities that emerge. Research is needed to identify different processes that are responsible for different outcomes, and eventually to explore how patterns of social transmission interact with biological vulnerabilities to guilt and depression.

Footnote

1. Collaborators on the NIMH research reported here include the following individuals: Marian Radke-Yarrow, Grazyna Kochanska, Robert King, Michael Chapman, Mark Cummings, Ronald Iannotti, Karen Caplovitz Barrett, and Pamela Cole.